The Managed Care Handbook:

A Resource Guide for Consumers, Families, and Advocates

Funded by
The Developmental Disabilities Council

Produced Jointly by
The Shriver Center & Suffolk University
1997

Written and Compiled by
James E. Spink MPA/Disability Policy

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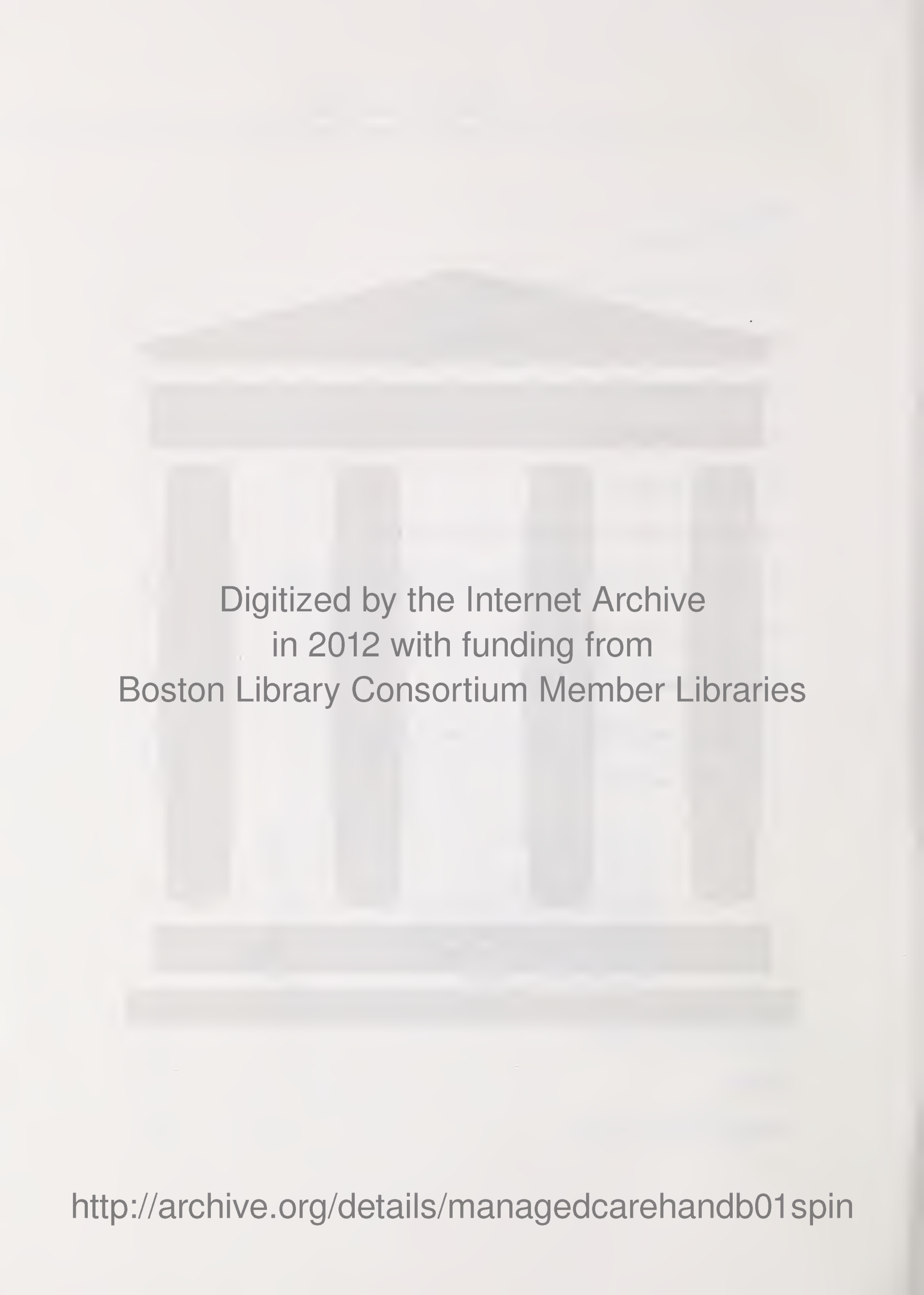

Dear Consumer, Advocate, and Friend,

In the Fall of 1996, The Shriver Center and Suffolk University began a series of seminars designed to educate and empower people with developmental disabilities, their families, and their caregivers to the complexities of the managed care system. To this end, the Managed Care Handbook was created. At the training seminars, participants included people with developmental disabilities and their family members, providers and advocates. This handbook is a compilation of wishes, suggestions and needs as identified by this diverse group. It is the hope of the staffs at The Shriver Center and Suffolk University that this publication becomes an essential reference as consumers and their advocates successfully utilize managed care systems.

The Managed Care Handbook was funded by The Massachusetts Developmental Disabilities Council and is a joint endeavor between the Shriver Center and Suffolk University.

We hope to periodically update this handbook, and welcome your suggestions for additional information to include. Please send your ideas and comments to:

Dr. Richard Beinecke
c/o Suffolk University
Public Management Department
Beacon Hill
8 Ashburton Place
Boston, MA. 02108-2770

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Acknowledgements

This manual for service users could not have been completed without the generous efforts of the people with developmental disabilities, their families and caregivers who identified the content, suggested the organization, and commented upon several drafts as it evolved into the document you are about to use. Those who attended the Managed Care Education Seminars were especially helpful in guiding this document. Experienced staff from agencies active in the struggle to ensure that managed care systems are quality care systems have provided helpful insight, such as the ideas from Mari-Lynn Drainoni, Medicaid Working Group; Betsy Anderson, Federation for Children with Special Needs; Stephanie Krantz, Disability Law Center, and Jim Gleason, Shriver Center. Dr.'s Richard Beinecke, Suffolk University, and Mary E. Brady, Shriver Center, wrote the initial proposal. Finally, deep appreciation goes to the Developmental Disabilities Council, without whose financial and practical support this document could not have been created.

Why the Managed Care Handbook

Currently, 60% of Massachusetts residents are in a managed care plan. You may be one. While some may have had to choose a managed care plan, most have selected them because they see benefits to them. Why is this happening? You probably know that health care costs have been sky rocketing for years. As a nation, we have been developing more and more ways to treat and care for all sorts of conditions -and that's good- but we haven't done as good a job figuring out what really helps people. Furthermore, there have been almost no "checks" on what professionals could recommend and be paid for. Our system has gotten out of control. Now there is an attempt to control costs . This is where managed care comes in. In this handbook we'll tell you a little about what these new managed care plans are all about beginning on page 4. And we will tell you what some have said the benefits are, as well as what some of the drawbacks of managed care may be, beginning on page 7.

In particular, we want to share some thoughts with you about how managed care may impact those with disabilities and special health care needs. Lots of people with disabilities are being asked to join or are choosing to join managed care plans. What are the special things to consider? What resources might provide further information?

Above all, we want to ensure that those with disabilities have access to the care they need and that they benefit from the care provided. We want to ensure that health care is about health!

INTEGRATED DELIVERY SYSTEMS

Health, as well as many social service programs are evolving to become integrated organized delivery systems. These new systems seek to provide a coordinated health care delivery system where all health care needs are met in an effective efficient manner which is accessible to all.

"An organized delivery system is a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held fiscally and clinically accountable for the health status of that population. It owns, or has a close relationship with an insurance product. It also has linkages with broad based public health and social services and may serve as the "umbrella" or catalyst for community care networks."

STEPHEN SHORTELL, PH. D. ET AL
"THE HOLOGRAPHIC ORGANIZATION"
HEALTH CARE FORUM JOURNAL
20, MARCH/APRIL 1993

Current changes in health care delivery reflect a major shift in philosophy about care giving which may be summarized as follows:

A New Paradigm
of Health Care Delivery

FROM TRADITIONAL CARE	→	TO MANAGED CARE
Acute Inpatient Care		Continuum of Care
Fragmented Systems		Integrated Systems
Episodic Care		Being Responsible For Peoples Lives Long-term
Managing Sickness		Managing Overall Health
Curing Distinct Medical Problems		Disease Prevention
Single Disciplinary Practice		Multi-disciplinary Teams
Passive Consumer		Active Participation of Consumer and Families
Separate Provider and Payer		Integrated Financing Systems
Consumers Simply Paying Bills		Consumers Buying Value
Little Provider Risk		Shared Risks
Little Accountability		Great Accountability
Few Outcome and Service Measures		Much Measurement of Outcomes and Services
Internal Utilization Review		External Utilization Review To Internal Total Quality Management with Oversight

What is Managed Care?

Managed care is the most common type of integrated health care delivery system. It is a way of providing pre-paid health care within a network that includes a specified group of health care providers and services. Managed care is different from traditional pay as you go unmanaged care in three major ways.

First, patients or customers usually receive services from a network of providers which may include hospitals, residential treatment facilities, pharmacies as well as a wide variety of outpatient services such as home care and personal assistants. These services may be directly owned and run by the managed care organization or may be independent programs contracted out by the managed care company.

Second, a "gate keeper" must review and approve all services in order to ensure that services which are considered unnecessary or referrals which are outside of the network are kept to a minimum. This gatekeeper seeks to ensure that consumers are helped to receive the most appropriate services in a coordinated continuum of care. The gate keeper may be a physician, nurse, social worker, or case manager.

Third, systems are "capitated." Capitation is a system where a consumer joins and becomes a member of a health care system, pays one fee and very few other out-of-pocket expenses, and for this receives all of the plan's covered benefits. Typically, in managed care there are few large co-payments, deductibles, or other financial limits. Providers such as physicians, some hospitals, and other organizations, instead of billing for each service, are paid "per-member/per-month." That is, they are paid a set fee for every managed care member who selects them as their primary provider, no matter how much or how little care they actually provide. If a provider's/physician's expenses are higher than their established (capitated) fee, the physician/provider loses money. If expenses are lower, the physician/provider makes money. Thus the financial incentives move from providing in-hospital to alternative forms of care, from longer to shorter lengths of stay, and from providing more costly to less costly forms of care.

Types of Managed Care

Many forms of managed care exist, and systems are still evolving. From **most** to **least** managed, they include:

Health Maintenance Organization (HMOs) generally provide all health services in a one stop shopping model. A consumer must receive all health services from the HMO or its affiliate, or pay additional fees when care is received elsewhere. HMOs may be:

Staff Model HMO:
HMO staff provide most out patient, lab, and diagnostic services, usually in one large center as well as through affiliated hospitals, nursing homes, and other facilities which in some cases are owned by the HMO.

- The Health Centers of Harvard Pilgrim are examples of **Staff Model HMO.**

Network or Group Model HMO:
Outpatient and related services are provided through independent multi-speciality groups, affiliated with the HMO.

- The medical groups in Harvard Pilgrim (before its merger) were a **Network Model HMO.**

Independent Practice Association (IPA) HMO:
Primary outpatient networks are individual physicians and other professionals.

- Pilgrim, Tufts, and the former Bay State are **Individual Provider Associations.**

Preferred Provider Organizations (PPO)

Preferred provider plans offer a group of doctors and hospitals who give a discount on their services to an insurance company or employer. In a PPO, consumers must choose their primary health provider from an approved list and must pay extra for specialty services received outside the PPO group.

- Currently, Tufts offers a **Preferred Provider Organization.**
- Medicaid's Primary Clinician Plan is a **Preferred Provider Organization.**

Medicaid Managed Care

Many states have adopted **Medicaid Managed Care** plans that restrict Medicaid recipients to certain networks of physicians. Massachusetts has moved towards this model.

Since 1992, Massachusetts Medicaid recipients have had a choice of two forms of managed care:

(1) Joining selected HMO's.

(2) Receiving health care through the Primary Clinician Program **(PCP)**. The PCP program is a program where physicians contract with Medicaid to provide medical care to Medicaid recipients. For Medicaid recipients, mental health and substance abuse services are received through a "carved out" network of providers who are managed by a private company; currently the Massachusetts Behavioral Health Partnership.

- A special Medicaid program run by Community Medical Alliance **(CMA)** provides comprehensive medical services to individuals with severe physical disabilities and mental retardation. CMA has received high marks for customer satisfaction, and is well worth investigating.

- Medicare and Champus (insurance for active military persons and their dependents) are moving rapidly towards managed care systems.

***Consumers should remember that most managed care organizations only provide short term acute care, not long term care. For example, Medicaid primarily covers acute care, while most **outpatient** long term or chronic care is provided through the Department of Mental Health or Department of Mental Retardation systems.

Potential benefits and potential limitations of Managed care.

Identified by <u>The National Alliance of Mentally Ill.</u>

POTENTIAL BENEFITS OF MANAGED CARE

- Through coordination of services, access to treatment and services will improve.
- The quality of treatments and services will improve due to quality assurance measures.
- Rather than awaiting acute episodes, emphasis will be placed on preventative care.
- Links between treatments and support services will be readily identified.
- Unnecessary hospitalizations will decrease, as coordination of care is realized.
- More attention will be focused on consumer satisfaction as a measure of quality care.
- Consumers will develop a stronger provider patient relationship resulting in better communication of health care needs.

POTENTIAL LIMITATIONS OF MANAGED CARE

- Fewer treatments and services will be available due to financial constraints.
- Hospital care will be denied and greater problems will result.
- Necessary services will be denied and conditions may worsen.
- Current doctor or mental health provider will not be part of your network of physicians.
- The system of care which I know will be disrupted and my health will suffer.
- Links between treatments and support services will be disrupted.
- I will have less ability to choose my own doctor or mental health provider.
- Outsiders who do not know my community will replace established providers.
- Consumers will have no say in how their own treatments are provided.

If you have the option of choosing a health plan, you might want to get answers to some of these questions.

Access to Providers and Services

- Is my current doctor or hospital part of the plan?
- Will I be able to change my doctor if I'm not satisfied with my care?
- Will I be limited in the number of times I can visit my doctor?
- Can I choose my specialists?
- Do I need a referral from my primary care physician each time I see a specialist?
- Are there specialists with knowledge about ***your disability*** in the plan?
- How far are the doctors' offices and hospitals from my home?
- Are the offices and other medical facilities physically accessible?
- Can I see a doctor outside the plan? Is there an extra fee for doing so?
- Do I have to pay extra if I want a second opinion?
- What is the appeals process if I disagree with my doctor?
- Is there a patient advocate available? What about a complaint line?
- What is the process for getting care outside the *system*?
- Do I need approval before going to the hospital emergency room?

Plan Coverage

- What is the plans definition of pre-existing conditions?
- Does the plan cover preventive care and ordinary check-ups?
- Does the plan cover the full range of medically necessary services for persons with, ***your disability*** including home based services and rehabilitation services?
- Does the plan cover post-hospitalization home care?
- Does the plan cover durable medical equipment? How often will the plan pay for ***the equipment I use?***
- Does the plan offer prescription medications coverage?
- Does the plan limit the number of hospital stays for each illness?
- What happens if I am out of town and I become ill?
- How is mental health treatment covered and to what extent?
- How do I access emergency care?

Expenses

- What is the amount I have to pay for the plan?
- What is the deductible? (the amount I must pay before the plan pays the rest)
- Is there a co-payment per doctor visit? (co-payments usually range form $3-$10)
- Is there a co-payment for prescriptions?
- Is there a lifetime maximum amount the plan will pay for prescriptions or equipment?

10 Things You can Do to Be an Empowered Consumer

1. **Know and understand your own conditions and needs.**

2. Know and understand the benefits and conditions of your health insurance plan. Remember: You are the customer. Providers and Managed Care companies need to provide you care that is accessible, of high quality, and cost effective if they are to have your business.

3. Be a smart consumer. Ask your doctor and other providers lots of questions.

4. Document and keep copies of all records and correspondences. Write summaries of important phone calls and always get the name of the person you are talking to.

5. Do not be afraid to discuss problems and complaints; first with your doctor or provider and then to the member services or quality assurance department.

6. Know the grievance and appeals process and use it when necessary.

7. Complete consumer satisfaction surveys, providing honest and detailed feedback.

8. Participate actively in consumer advisory boards.

9. Stay active with your advocacy groups and help them to collect information on the benefits and problems of managed care.

10. Share what you know with your peers.

Some Common Questions and Answers

Q. **How do I learn more about my physician, or other physicians in my health plan?**

A. If you would like to learn more about a particular physician in your health care plan, you might first talk to others you know who use this doctor. More formally, ask the plan's customer service representative for a summary of their background. Also, you can set up an appointment to interview a physician. Remember, as the consumer it's your right to make an informed decision.

Another option is to call the Massachusetts Board of Registration in Medicine at their toll free number; **1-800-377-0550**. Through this board, you can receive information on any licensed physician in Massachusetts. Information available includes the physician's educational background, their specialty affiliation, and any malpractice or disciplinary history.

Q. **Is it true that all Medicaid recipients will soon be in managed care programs? How do I find out how this might affect me?**

A. If you are currently receiving Medicaid, you may be asked to move into a managed care primary clinician plan. For specific information on how this may personally affect you, call the MassHealth customer service line at **1-800-682-1062; TTY 1-800-497-4648** and request information on MassHealth managed care. A pamphlet which is helpful is, ***How to join MassHealth managed care***. Copies are free of charge.

Q. **How do I change my physician?**

A. Each managed care health plan has a different procedure for changing physicians. Some only allow changes during a specific time period called an "open enrollment period", others are more flexible. Contact your member service representative to find out the specifics of your plan. Creating a "paper trail" is very important. Remember, document your phone conversations and request all information in writing.

Q. Can I appeal an HMO decision?

A. All members enrolled in an HMO have the right to appeal a decision which denies or modifies care. Massachusetts law requires the HMO to give you a copy of its policy for resolving member complaints. Each policy is a little different, but most involve a two or three step process. You can begin by discussing your concerns with your physician. If this does not resolve the problem, you can contact member services and look in your policy for the HMO grievance procedure.

Q. I am not satisfied with the quality of care I am receiving in my health plan, what should I do.

A. First, make sure to discuss your concerns with your physician or provider. Consider your reasons for dissatifaction, ie. is the problem interpersonal, or is it a lack of response from your physician to your particular needs? You are the best person to educate providers to your needs. If, after discussing your situation, you are still not satisfied, contact your health plan's customer service representative. You can also call or send a letter to your plan's quality assurance department with details of your case and ask for a review and remedy. At this point you may want to find out about how to file a grievance. Remember to document your conversations. If all else fails, contact one of the advocacy groups listed in this handbook and ask them for help.

Q. What other steps can I take.

A. If you believe that your HMO is not providing you with the services in your policy, you can file a complaint with the Massachusetts Division of Insurance. This is the State agency that regulates insurance companies. A detailed complaint with supporting documentation can be mailed to the:

Division of Insurance
470 Atlantic Avenue
Boston, MA 02210-2223
Attn: Consumer Services

Medicaid Managed Care Questions and Answers

Q. Can I appeal a Medicaid managed care decision?

A. Yes. Appealing unfavorable decisions can make a difference and is an important way to have your voice heard.

Q. I wish to appeal a Medicaid decision, how do I do this?

A. Medicaid recipients have the right to appeal any denial, modification, or termination of services. These protections cover Medicaid recipients who have enrolled in an HMO and those with a Primary Care Physician. Medicaid is required to send written notice of any denial, modification, or termination of services and this notice **must** include information about your right to appeal and a form to request a hearing. There are time limits for appeal, so read the notice carefully. It is recommended that you mail the hearing request ***return receipt*** to prove your request was made within the time limits.

Q. How do I prepare for a Medicaid hearing?

A. It is important to get medical documentation to support you claim. You can bring a doctor or other medical professional to the hearing to help support your case. If he/she is unable to attend they can write a letter that you can bring with you to the hearing. It is important that the letter clearly supports your claim for services. It is helpful to write out notes before the hearing and to bring copies of any documents or medical records that may help your case.

Q. What will happen at the hearing?

A. You will be given an opportunity to present your side of the story, present witnesses, and ask questions. The hearing is taped and all witnesses must take an oath. At the end of the hearing, you will have an opportunity to give a closing statement.

Q. Can I appeal a Medicaid Hearings decision?

A. Yes. If you are enrolled in a Medicaid HMO, you have additional rights of appeal. Medicaid recipients who have enrolled in an HMO have the option of appealing through the Medicaid appeals process or appealing directly with the HMO. You can request a Medicaid hearing, and then try to resolve the problem with the HMO while waiting for a hearing date. It is important to remember that the time limit for the Medicaid appeals process and the HMO appeals process are probably different.

Information & Referral

Disability Advocacy

Arc Massachusetts
217 South Street
Waltham, MA 02154
(617) 891-6270
http://www.gis.net/~arcmass

Disabled Persons Protection Commission (DPPC)
99 Bedford Street, Room 200
Boston, MA 02111
(617) 727-6465 1-800 245-0062 (voice & TTY)
24 Hr. Hotline 1-800 426-9009 (voice & TTY)

Massachusetts Developmental Disabilities Council (MDDC)
174 Portland Street, 5th Floor
Boston, MA 02114
(617) 727-6374

Massachusetts Office on Disability (MOD)
One Ashburton Place, Room 1305
Boston, MA 02108
(617) 727-7440 (800) 322-2020

Legal Advocacy

Disability Law Center (DLC)
11 Beacon Street, Suite 925
Boston, MA 02108
(617) 723-8455 (800) 872-9992
TDD (617) 227-9464 (800) 381-0577

Greater Boston Legal Services
197 Friend St.
Boston, MA 02114
(617) 371-1234
1-800-342-5297

Massachusetts Law Reform Institute
99 Chauncy Street
Boston, MA
(617) 357-0700

Health Care Advocacy

Division of Insurance
470 Atlantic Avenue
Boston, MA 02210-2223

Health Care For All
30 Winter Street Suite 1007
Boston, MA 02108
(617) 350-7279

Massachusetts Board of Physician Registration
10 West Street
Boston, MA 02111
1-800-377-0550

Family Advocacy & Resources

Family Ties Project
Department of Public Health
250 Washington Street, 4th Floor
Boston, MA 02108
(800) 905-8437

Federation for Children with Special Needs
95 Berkeley Street, Suite 104
Boston, MA 02116
(617) 482-2915 (800) 331-0688
http://www.fcsn.org

Institute for Community Inclusion
Children's Hospital Medical Center
300 Longwood Avenue
Boston, MA 02115
(617) 355-6506

National Parent Network on Disability
1727 King Street, Suite 305
Alexandria, VA 22314
(703) 684-6763
http://npnd.org

Resource and Referral Databases

The Bazelon Center for Mental Health Law and the Federation of Families for Children's Mental Health
(202) 467-5730

Family Voices
A grassroots coalition addressing health care reform for families of children with special needs.
P.O. Box 769
Algodones, New Mexico 87001
(505) 867-2368 Internet: famv01rw@wonder.em.cdc.gov

Mass Child Care Resource and Referral Network (CCR&R)
(800) 345-0131

Massachusetts Network of Information Providers (MNIP)
Shriver Center UAP
200 Trapelo Road
Waltham, MA 02154
(617) 642-0248 (800) 642-0249

The Medicaid Clearing House
A web site to find out the latest on state and federal Medicaid law.
http://www.handsnet.org/medicaid

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, D.C. 20013-1492
(800) 695-0285
http://www.nichcy.org

New England INDEX
Shriver Center UAP
200 Trapelo Road
Waltham, MA 02154
(617) 642-0248 (800) 642-0249

National Organization for Rare Diseases (NORD)
100 Route 37
P.O. Box 8923
New Fairfield, CT 06812-1783
(800) 999-6673
http://www.pcnet.com/~orphan/

Massachusetts State Resources

Commonwealth of Massachusetts Home Page
http://magnet.state.ma.us/home.htm

Public Benefits Information Line
MA Department of Public Health (DPH)
250 Washington Street, 4th Floor
Boston, MA 02108
(800) 882-1435

Department of Mental Health (DMH)
25 Staniford Street
Boston, MA 02114
(617) 727-5500

Department of Mental Retardation (DMR)
160 North Washington Street
Boston, MA 02114
(617) 727-5608 TDD only (617) 727-9866

Department of Public Health (DPH)
Bureau of Family & Community Health
Department of Public Health
250 Washington Street, 4th Floor
Boston, MA 02108
(617) 624-5070 TDD only (617) 624-6001
http://www.state.ma.us/dph

Department of Social Services (DSS)
24 Farnsworth Street
Boston, MA 02210
(617) 727-0900 TDD only (617) 261-7440
http://www.state.ma.us/dss

Division of Medical Assistance (DMA)
600 Washington Street
Boston, MA 02111
(617) 348-5600

Massachusetts Behavioral Health Partnership
Customer Service
1-800-495-0086

MassHealth Customer Service Line
1-800-841-2900 1-800-497- 4648 TTY

Department of Transitional Assistance (DTA)
600 Washington Street
Boston, MA 02111
(617) 348-5600
http://www.state.ma.us/dta

Massachusetts Commission for the Blind (MCB)
88 Kingston Street
Boston, MA 02111
(617) 727-5550 1-800-392-6450
!-800-392-6556 TDD only
http://www.state.ma.us/mcb

Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH)
210 South Street, 5th Floor
Boston, MA 02111
TTY only (671) 695-7600
(617) 695-7500 1-800-882-1155 TDD also
Emergency Interpreter 1-800-249-9949

Massachusetts Rehabilitation Commission (MRC)
Fort Point Place
27-43 Wormwood Street
Boston, MA 02210
(617) 727-2183 TDD only (617) 727-9063
1-800-245-6543
http://www.state.ma.us/mrc

Social Security Administration (SSA)
JFK Federal Building Room 1900
Boston, MA 02203
(617) 565-5590
http://www.netguys.com:80/feb/ssa.htm
Federal Social Security Admin. (800) 772-1213

PRINTED RESOURCE GUIDES

Association for the Care of Children's Health
Parent Resource Directory
(301)654-6549

Communication for Health, a Family Resource Manual
Shriver Center, 1990
(617) 642-0001

Family TIES Resource Directory
Massachusetts Department of Public Health, 1997
(617) 727-8900 1-800-905-8437

Family Voices
Health Care reform for families; bulletins, written materials, and advocacy for systems change. Family voices offers a comprehensive publications list.
(505)867-2368

National Information Systems Clearinghouse: Center for Developmental Disabilities
Benson Building
University of South Carolina
Columbia, South Carolina 29208
(800) 922-9234

National Parent to Parent Support and Information System, Inc.
Links parents to other parents and to parent groups
(800)651-1151

Working Toward a Balance in Our Lives: A Booklet for Families of Children With Disabilities and Special Health Care Needs $10.00
Project School Care
Children's Hospital
Boston, MA 02115
(617) 355-6714

How to Join MassHealth Managed Care
Department of Medical Assistance
Customer Service Center
1-800-682-1062
1-800-497-4648 TTY

MASSACHUSETTS ASSOCIATION OF HMO's MEMBERS LISTING

Below is a partial listing of the Massachusetts Association of HMO's member directory. For a complete listing, call (617) 523-0344.

Aetna/US Healthcare
Three Burlington Woods Drive
Burlington, MA 01803
(617) 273-5600

CIGNA Health Plan
20 Speen Street
Framingham, MA 01701-4680
(508) 935-2100

Fallon Community Health Plan
Chestnut Place
Ten Chestnut Street
Worcester, MA 01608-2810
(508) 799-2100

Harvard Pilgrim Health Care
10 Brookline Place West
Brookline, MA 02146
(617) 421-3530

Health New England
One Monarch Place
Springfield, MA 01144-1006
1-(800) 842-4464

- **Community Medical Alliance**
  441 Stuart Street
  Boston, MA 02116
  (617) 437-1400
  (617) 859-0750 TTY

- **HMO Association of Massachusetts**
  (617) 523-3300
  18 Tremont Street Suite 305
  Boston, MA 02108-2301
  (617) 523-0344

Healthsource CMCH
Bank of Boston, Worcester Tower
100 Front Street, Suite 300
Worcester, MA 01608
(508) 799-2642

Kaiser Permanente
76 Batterson Park Road
Farmington, CT 06034
(860) 678-6000

Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
(617) 772-5500

Tufts Associated Health Plan
333 Woman Street
Waltham, MA 02254
(617) 466-1018

United HealthCare of N.E.
475 Kilvert Street
Warwick, RI 02886
1-(800) 447-1245

A special HMO for Medicaid recipients serving persons health severe physical disabilities and mental retardation.

GLOSSARY

Appeal: A formal request by an insured person or provider for reconsideration of a decision, for example; a benefit service reduction or provision decision. The goal of appealing is to advocate for your needs and find a mutually acceptable decision.

Capitation: A pre-defined dollar amount established to cover the cost of health care delivery for a person. This rate is paid to the health care provider who then is responsible for delivering or arranging for the delivery of all health services required by the person.

Carve Out: The separation of a service from a traditional all service models. For example, an HMO may "carve out" an orthopedic benefit and select another vendor to supply these services just as Medicaid "carves out" its mental health and substance abuse services to Behavioral Health Partnership.

Case Manager: An individual who works with a consumer and/or family to develop a plan which effectively identifies needs and establishes a plan to meet those needs.

Co-Payment: The cost sharing arrangement in which the insured person pays a specific charge for certain services. For example, a patient may pay $10.00 for a visit to the Doctor's office. This amount is the consumers co-payment.

Deductible: The amount an insured person must pay before a provider will reimburse for a service. Deductibles vary from plan to plan: some offer no deductible, others a pre-determined amount for covered services.

Durable Equipment: Equipment designed to be used repeatedly such as a wheelchair, or leg braces.

Fee-for-Service: The traditional health care payment system whereby physicians and other providers received payment each time a service was provided.

Gate Keeper: A situation in which a primary care physician, or a nurse practitioner, "the gatekeeper," serves as the patient's initial contact for medical care and all referrals.

Group Model HMO: A health care model involving contracts with physicians organized into a partnership or association. The health plan compensates the medical group for services at a pre-negotiated rate.

HMO: Health Maintenance Organization. An entity licensed by the state that provides, offers or arranges for coverage of health services needed by plan members for a fixed, prepaid amount.

Independent Practice Association HMO: A health maintenance model where primary outpatient networks are individual physicians and other professionals contracted to an HMO for a negotiated fee-for-service rate.

Managed Care: A system of health care delivery where a primary physician or other provider directs and refers a patient's care. The goal of managed care is to deliver value by providing people access to quality, cost-effective health care.

Medicaid: A joint federal-state program, enacted in 1965 under Title XIX of the Social Security Act, which provides medical benefits to eligible low-income persons. The programs costs are shared by the federal and state governments and coverage varies state by state.

Medically Necessary: A term used to refer to the medical services which are required for proper treatment of an illness.

Medicare: A totally federally run and financed health insurance plan authorized under Title XVIII of the 1965 Social Security Act for eligible persons over the age of 65 and certain qualifying individuals with disabilities.

Network Model HMO: A health maintenance organization model where many physicians are contracted to the HMO and work out of their own offices. Doctors in a network model may provide health care to non-HMO members.

Open Enrollment Period A time during which subscribers in certain health programs have an opportunity to re-enroll, select an alternate insurance plan, or choose a new primary physician.

Pre-existing Conditions: Any medical condition that has been diagnosed or treated within a specified period prior to joining a new insurance plan. Time considered pre-existing varies from plan to plan.

Primary Care Physician: A physician chosen to be an individuals primary practitioner. Most often primary care physicians practice general medicine, internal medicine or family medicine.

Prior Authorization: The process of obtaining prior approval from a "gate keeper" as to the appropriateness of a sought after service.

Provider:	Health care professionals including: physicians, hospitals, therapists, or any individual or group of individuals providing a health care service.
Quality Assurance:	A formal set of criteria used to evaluate the quality and cost-effectiveness of services rendered.
Referral:	The recommendation of a physician for a covered person to receive treatment from a different physician, facility, or specialist not in the plan.
Second Opinion:	An opinion obtained from an additional health care professional prior to the performance of a medical service.
Staff Model HMO:	A health maintenance model where physicians are contracted to provide health care to HMO members, and are compensated by the contractor via salary and incentive programs.

Common Abbreviations

DLC	Disability Law Center
DMA	Department of Medical Assistance (MassHealth or Medicaid)
DMH	Department of Mental Health
DMR	Department of Mental Retardation
DPH	Department of Public Health
DPPC	Disabled Persons Protection Commission
DTA	Department of Transitional Assistance (Welfare)
DSS	Department of Social Services
HMO	Health Maintenance Organization
IPA HMO	Independent Practice Association
MCB	Massachusetts Commission for the Blind
MCDHH	Massachusetts Commission of Deaf and Hard of Hearing
MDDC	Massachusetts Developmental Disabilities Commission
MLR	Massachusetts Law Reform
MNIP	Massachusetts Network of Information Providers
MOD	Massachusetts Office on Disability
MR	Mental Retardation
MRC	Massachusetts Rehabilitation Commission
NORD	National Organization of Rare Diseases
OFC	Office For Children
OT	Occupational Therapy

PA	Prior Authorization
PCA	Personal Care Assistant
PCC	Primary Care Clinician
PCP	Primary Care Physician
PPO	Preferred Provider Organization
PRN	Whenever Necessary
PT	Physical Therapy
SSI	Supplemental Security Income
SSDI	Social Security Disability Income